TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MedAlert Occupational Management

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-1122-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The requestor maintains that all information required by the Texas Administrative Code has been submitted to the Carrier and services provided by our office on behalf of the insured are due proper reimbursement."

Amount in Dispute: $88.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2016	99080, L4350	$88.00	$88.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out the reimbursement guidelines for work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

- P12 – Workers' compensation jurisdiction fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier

Issues

1. Are carrier's denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is payment due for work status report?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for a work status reports and durable medical equipment provided in an office setting on July 26, 2016.

   The insurance carrier denied disputed services with denial code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication" and P2 – "Not a work related injury/illness and thus not the liability of the workers compensation carrier."

   These denials are reviewed per the applicable Division rules as follows:

   28 Texas Administrative Code §133.210 (a) and (b) states

   > (a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.
   >
   > (b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

   Review of the submitted information finds the office exam note dated July 26, 2016 includes the following; "Recommended work status (claimant's) recommended work status is Regular Duty" and "Durable medical equipment he was given an air stirrup to allow him to wean off the 3D walking boot to limit his weight bearing and decrease swelling, pain, facilitate recovery."

   Therefore, the carrier's denial for lack of information not upheld.

   Regarding the denial P2 – "Not a work related injury/illness and thus not the liability of the workers' compensation carrier."

   28 Texas Administrative Code §133.307(2)(H) states,

   > If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

   Insufficient evidence found to support a Plain Language Notice was issued. Therefore, the services in dispute will be reviewed per applicable fee guidelines.

2. The reimbursement guidelines pertaining the Durable Medical Equipment is found at 28 Texas Administrative Code §134.203 (d) which states,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Review of the applicable DMEPOS fee schedule found at www.cgsmedicare.com, finds the following:

- Code L4350 – "Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, off-the-shelf."

  The allowable shown is $81.95. The maximum allowable reimbursement calculation is $81.95 x 125 % or $102.44. However the submitted charge or usual and customary charge found on the claim line $73.00. Therefore the provisions of 28 Texas Administrative Code 134.203(h) applies which states,

  When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

  (1) MAR amount;

  (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

  Based on the above the amount payable is $73.00.

3. 28 Texas Administrative Code §129.5 (i) states in pertinent part,

   Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows:

   (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section;

   Review of the submitted medical claim finds the provider submitted code 99080 with the "73" modifier. Within the submitted documentation, a copy of "Work status report" dated July 26, 2016 was found. Therefore, based on the above the provider has met the Division guidelines and $15.00 allowed.

4. The total allowed amount is ($73.00 + $15.00) = $88.00. The carrier previously paid $0.00. Therefore, the remaining balance of $88.00 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $88.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $88.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		January 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.